Appendices

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- How should the VA establish priorities for providing long-term care when demand exceeds resources?
- Should there be limits placed on the length of time long-term care is provided to veterans at VA expense? Should limits vary by program?
- What is our ongoing obligation to patients who have been provided long-term care by VA for extended periods?

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- How should long-term care programs enhance the Department's move from a hospital-based system to one focused on ambulatory and primary care?
- What should be the mix of institutional versus home- and community-based long-term care services?
- What should be the relative size of the nursing home programs?
- Is there a specific role for VA-operated, hospital-based nursing home units?

VA Long-Term Care in the Context of the Overall VA Health Care System

- How can current and planned data systems support the ongoing review of VA long-term care policy and the development of appropriate outcome measures?
- What is the adequacy of the linkages to other critical components of VA's health care system, such as case management, geriatric evaluation and management programs, and primary and ambulatory care?
- Given VA's historical leadership in academic geriatric medicine, which areas of long-term care investigation should be the budget priority for VA over the next five to 10 years?

Investment

- What are the likely long-term care needs (nursing home, home care, other community-based long-term care services) of veterans through 2010?
- What portion of those long-term care needs should be met by VA (what is the appropriate market share)?
- What importance should be given to construction of VA and State Nursing Home care projects?

Appendix B:

The Committee's Recommendations

Following are all of the recommendations of the Committee, listed by subject area.

A Roadmap To LTC Delivery

- VA should maximize network flexibility in developing and restructuring its long-term care services within broad national policies.

- VA must create a series of financial incentives and performance measures to ensure that adequate access to long-term care services is provided to veterans.

Targeting The Demand For Services

- VA should retain its core of VA-operated long-term care services while improving access and efficiency of operations. Most new demand for care should be met through non-institutional services, contracting, and, where available, State Veterans Homes.

- The Long-Term Care Planning Model offers an objective measure of service needs. The Department should continue to refine this population-based Planning Model, using the latest available data.

- To meet the needs of veterans who are eligible for, and use, VA for their healthcare needs, planning for long-term care should be based on Category A veterans.

Current Service Offerings

- VA should expand options and services for home- and community-based care, making these services the preferred placement site, when clinically appropriate, for veterans needing long-term care. The service mix should be based on the care needs of the veteran population and the availability of services in local communities.

- VA should increase its investment in home- and community-based care from 2.5 percent to 7.5 percent of VA healthcare budget.

- Within VA long-term care spending, the proportion of home- and community-based care and enriched housing should double — to 35 percent of total long-term care expenditures.

- Additional educational efforts and other collaborative ventures between long-term care and mental health program staffs are strongly encouraged.

- VA needs to maintain its three nursing home programs. Home- and community-based services cannot substitute for nursing home care for most of the veteran population. VA should use its own hospital-based nursing home beds to provide care to post-acute patients, patients who cannot be cared for in other nursing home programs, and those patients who can be cared for more efficiently in VANHs.

- VA should implement and enhance its existing written policies on CNH placement. Length of CNH placements should be based on patient care needs, not fiscal goals.

- In FY 1997, 12.3 percent of veterans in VANHs had lengths of stay in excess of one year. VA should take necessary steps to ensure that VANH patients who no longer require hospital-based nursing home care are properly transitioned into home- and community-based care programs. Patients who require nursing home care, and have received care for more than 1,000 days, and desire to remain in the nursing home, should be allowed to remain in the VANH.

- In an era of limited budgetary resources, VA should not seek funding for any new nursing home beds, except for approved projects that are justified by objective standards that include a measure of community capacity and national policy goals. Renovation projects that affect the number of beds also should be rejustified. Renovation projects that affect patient privacy and life safety issues should receive first priority.

- VA should establish system-wide care coordination processes, based on a comprehensive assessment of patients requiring long-term care services. A standardized core assessment, upon which VISNs or facilities can add criteria to meet individual objective or target improvements, should be the baseline. VA should reassign and train existing staff to implement such processes.

Taking Action, Legislatively

- VA should seek legislative authority to broaden respite care in 38 U.S.C. 1720B, to include its provision in all settings.

- VA should seek legislative authority to allow for the payment of assisted living/residential care under 38 U.S.C. 1730.

- VA should seek legislative authority to include a limited, 100 days/patient/year nursing home benefit following a period of VA hospitalization under 38 U.S.C. 1710 and 1720, notwithstanding current nursing home rules and policies.

Adjunct Issues

- VA should implement its plans for RAI/MDS without delay.
- At least 5 percent of VA's research appropriation should support health services, rehabilitation, and other research, related to long-term care issues. The research should emphasize:
  - Testing the effectiveness of VA long-term care programs and services, using cost and clinical outcomes that can be compared to the private sector;
  - Examining the effectiveness of clinical interventions, for treatment and management of psychiatric disorders in veterans using long-term care services. Non-pharmacological as well as pharmacological interventions should be included;
  - Comparing the effectiveness of post-acute care provided by VA to the private sector; and
  - Exploring the effectiveness of providing acute care services in the home.
- VA should continue its leadership role in the training of physicians and associated health professions in geriatrics and long-term care. VA also should continue to utilize its expertise at GRECC and other VA sites to train VA staff in areas such as care coordinationfor complex patients. VA training should be supported by long-term care environments that can adequately prepare trainees for future practice.

Appendix C:
Accountability and Incentives Ideas

Access To Care

Idea: VA should adopt a performance measure for Access to Care which rewards networks for:

- Increasing their share of long-term care services to the national VA average; or
- Maintaining their share of long-term care services, if that share is above the national average.

Cost/Price

Idea: VA should adopt a performance measure for Cost/Price which rewards networks for lowering the average cost of long-term care patients by 5 percent per year. This measure should be used only in conjunction with meeting the access measure above.

Quality/Functional Status

Idea: VA should develop a composite Long-Term Care Quality Index, using evidence-based indicators that are realistic and measurable. See Appendix E for suggested performance measures.

Patient Satisfaction

Idea: VA's National Customer Feedback Center should develop reliable patient satisfaction measures for veterans using long-term care services, including those in institutional settings. This program should be a high priority, and once developed, must be operated on a routine basis

Appendix D:
Network Tables

Table 1: Long-Term Care Needs of Veterans In 1997

	Long Term Care Census 1997	Long Term Care Category A Total Need 1997	Market Share
VISN 1 (New England)	4,640	16,743	27.7%
VISN 2 (Upstate NY)	2,548	7,340	34.7%
VISN 3 (Downstate NY)	4,135	15,383	26.9%
VISN 4 (PA & DE)	3,914	22,871	17.1%
VISN 5 (MD & DC)	1,524	7,685	19.8%
VISN 6 (VA & NC)	2,174	13,497	16.1%
VISN 7 (AL, GA & SC)	3,552	15,368	23.1%
VISN 8 (Florida)	2,927	22,575	13.0%
VISN 9 (KY & TN)	2,292	12,563	18.2%
VISN 10 (Ohio)	3,074	12,045	25.5%
VISN 11 (IN & MI)	2,997	17,799	16.8%
VISN 12 (Chicago & WI)	4,260	12,880	33.1%
VISN 13 (MN, ND & SD)	2,222	8,041	27.6%
VISN 14 (IA & NE)	1,794	5,167	34.7%
VISN 15 (KS & MO)	2,563	12,168	21.1%
VISN 16 (AR, LA, MS, OK)	4,196	23,666	17.7%
VISN 17 (Most of TX)	2,359	10,475	22.5%
VISN 18 (AZ, NM & W TX)	1,548	10,335	15.0%
VISN 19 (Rocky Mountain)	1,526	6,487	23.5%
VISN 20 (Pacific NW)	3,136	11,004	28.5%
VISN 21 (Northern CA)	2,991	13,462	22.2%
VISN 22 (Southern CA)	2,709	17,338	15.6%
Nation	63,081	294,892	21.4%

This table displays information on VA's provision of long-term care services and on veterans' need for those services. Column 2 shows the number of veterans who received long-term care services from VA in 1997 (directly, through contracts, or through State Veterans Homes). Column 3 shows the number of Category A veterans who needed long-term care services in 1997. Column 4, market share, shows the portion of the total need that VA provided. Nationally, VA provided 21.4 percent of the long-term care needed by veterans in 1997. All need data are shown in average daily census by network.

Sources: VA Long-Term Care Planning Model; AMIS and CDR Reports

Table 2: VA Spending for Long-Term Care Services

NETWORK	VHA MODEL ALLO. WITH EQUIP NRM	LTC EXPENDITURE TOTAL	PERCENT LTC OF VHA ALLO.	NH EXPEND. TOTAL	PERCETN NH OF TOT. OF ALLO.	EH EXPEND. TOTAL FY 97	PERCENT EH EXPEND. OF ALLO.	CBLTC EXP. TOTAL	PERCENT BLTC EXP. OF ALLO.
Network 1 (New England)	$ 855,000,000	$ 119,398,000	14.0%	$ 102,465,000	12.0%	$ 8,810,000	1.0%	$ 8,123,000	1.0%
Network 2 (Upstate NY)	$ 439,000,000	$ 75,380,000	17.2%	$ 54,869,000	12.5%	$11,643,000	2.7%	$ 8,868,000	2.0%
Network 3 (Downstate NY)	$ 1,029,000,000	$ 144,801,000	14.1%	$ 124,177,000	12.1%	$11,330,000	1.1%	$ 9,295,000	0.9%
Network 4 (PA & DE)	$ 777,000,000	$ 147,597,000	19.0%	$ 130,221,000	16.8%	$10,551,000	1.4%	$ 6,825,000	0.9%
Network 5 (MD & DC)	$ 425,000,000	$ 64,376,000	15.1%	$ 48,202,000	11.3%	$11,672,000	2.7%	$ 4,502,000	1.1%
Network 6 (VA & NC)	$ 682,000,000	$ 96,696,000	14.2%	$ 83,603,000	12.3%	$ 8,755,000	1.3%	$ 4,339,000	0.6%
Network 7 (AL,GA & SC)	$ 777,000,000	$ 91,150,000	11.7%	$ 78,573,000	10.1%	$ 7,675,000	1.0%	$ 4,903,000	0.6%
Network 8 (Florida)	$ 962,000,000	$ 108,371,000	11.3%	$ 92,480,000	9.6%	$ 5,873,000	0.6%	$ 10,018,000	1.0%
Network 9 (KY & TN)	$ 691,000,000	$ 60,369,000	8.7%	$ 47,571,000	6.9%	$ 9,151,000	1.3%	$ 3,647,000	0.5%
Network 10 (Ohio)	$ 511,000,000	$ 92,702,000	18.1%	$ 70,588,000	13.8%	$14,629,000	2.9%	$ 7, 485,000	1.5%
Network 11 (IN & MI)	$ 658,000,000	$ 91,029,000	13.8%	$ 84,096,000	12.8%	$ 1,208,000	0.2%	$ 5,725,000	0.9%
Network 12 (Chicago & WI)	$ 836,000,000	$ 132,644,000	15.9%	$ 108,895,000	13.0%	$13,103,000	1.6%	$ 10,646,000	1.3%
Network 13 (MN, ND & SD)	$ 420,000,000	$ 76,919,000	18.3%	$ 66,293,000	15.8%	$ 6,065,000	1.4%	$ 4,561,000	1.1%
Network 14 (IA & NE)	$ 289,000,000	$ 45,354,000	15.7%	$ 38,025,000	13.2%	$ 5,503,000	1.9%	$ 1,826,000	0.6%
Network 15 (KS & MO)	$ 585,000,000	$ 79,393,000	13.6%	$ 64,859,000	11.1%	$10,397,000	1.8%	$ 4,137,000	0.7%
Network 16 (AR, LA, MS, OK)	$ 1,078,000,000	$ 110,990,000	10.3%	$ 94,691,000	8.8%	$ 8,040,000	0.7%	$ 8,259,000	0.8%
Network 17 (Most of TX)	$ 588,000,000	$ 80,172,000	13.6%	$ 57,359,000	9.8%	$17,368,000	3.0%	$ 5,446,000	0.9%
Network 18 (AZ, NM & W TX)	$ 486,000,000	$ 64,925,000	13.4%	$ 53,273,000	11.0%	$ 5,849,000	1.2%	$ 5,802,000	1.2%
Network 19 (Rocky Mountain)	$ 369,000,000	$ 52,777,000	14.3%	$ 49,149,000	13.3%	$ 919,000	0.2%	$ 2,708,000	0.7%
Network 20 (Pacific NW)	$ 587,000,000	$ 89,287,000	15.2%	$ 55,791,000	9.5%	$26,575,000	4.5%	$ 6,921,000	1.2%
Network 21 (Northern CA)	$ 689,000,000	$ 98,647,000	14.3%	$ 81,065,000	11.8%	$ 9,699,000	1.4%	$ 7,883,000	1.1%
Network 22 (Southern CA)	$ 902,000,000	$ 91,016,000	10.1%	$ 75,058,000	8.3%	$ 8,256,000	0.9%	$ 7,702,000	0.9%
National	$ 14,635,000,000	$ 2,013,993,000	13.8%	$ 1,661,303,000	11.4%	$213,071,000	1.5%	$ 139,621,000	1.0%

This table shows VA's spending for long-term care services for each network and nationally. Total VA spending* is listed in Column 2, followed by VA's spending for long-term care (Column 3). Column 4 shows the portion of the budget spent on long-term care. Columns 5 and 6 show nursing home spending, followed by its percent of total spending; Columns 7 and 8 show spending for enriched housing, followed by the percent; Columns 9 and 10 display home- and community-based long-term care expenditures, followed by the percent. Nationally, VA spends 13.8 percent of its resources in long-term care, with 11.4 percent of the total budget spent in nursing home care, 1.5 percent in enriched housing, and 1 percent in home- and community-based care.

* Total VA spending in this chart consists of Medical Care funds distributed by the VERA model, equipment funds, non-recurring maintenance funds, and State Veterans Homes construction funds. This equals $14.6 million. All VA funds for healthcare totaled $17 million in FY 1997, but not all of these funds could be easily distributed among the networks.

Sources: VA VERA Book; State Home Construction Expenditures Report; CDR Report.

Table 3: VA Long-Term Care Workload, 1997

FACILITY NETWORK WORKLOAD	TOTAL NH OF TOTAL	NH PERCENT WORKLOAD	TOTAL HOUSING OF TOTAL	EH PERCENT WORKLOAD	TOTAL CBLTC OF TOTAL	CBLTC PERCENT WORKLOAD	TOTAL LTCSTATION
Network 1 (New England)	2,299.7	49.6%	1,651.1	35.6%	689.3	14.9%	4,640.1
Network 2 (Upstate NY)	907.3	35.6%	793.2	31.1%	847.4	33.3%	2,547.9
Network 3 (Downstate NY)	2,492.8	60.3%	955.2	23.1%	687.3	16.6%	4,135.3
Network 4 (PA & DE)	2,319.9	59.3%	1,007.3	25.7%	586.3	15.0%	3,913.5
Network 5 (MD & DC)	824.2	54.1%	498.9	32.7%	200.7	13.2%	1,523.8
Network 6 (VA & NC)	1,168.6	53.7%	763.3	35.1%	242.5	11.2%	2,174.4
Network 7 (AL,GA & SC)	2,236.3	63.0%	891.4	25.1%	424.6	12.0%	3,552.3
Network 8 (Florida)	1,402.4	47.9%	513.7	17.5%	1,011.2	34.5%	2,927.4
Network 9 (KY & TN)	1,137.0	49.6%	839.4	36.6%	315.8	13.8%	2,292.2
Network 10 (Ohio)	1,311.3	42.7%	1,174.2	38.2%	588.2	19.1%	3,073.7
Network 11 (IN & MI)	1,904.6	63.5%	448.8	15.0%	643.6	21.5%	2,997.0
Network 12 (Chicago & WI)	2,584.3	60.7%	856.5	20.1%	819.6	19.2%	4,260.4
Network 13 (MN, ND & SD)	1,153.2	51.9%	705.3	31.7%	364.0	16.4%	2,222.4
Network 14 (IA & NE)	1,292.1	72.0%	394.8	22.0%	106.7	5.9%	1,793.6
Network 15 (KS & MO)	1,432.5	55.9%	654.4	25.5%	475.8	18.6%	2,562.6
Network 16 (AR, LA, MS, OK)	2,791.0	66.5%	755.3	18.0%	649.3	15.5%	4,195.7
Network 17 (Most of TX)	926.8	39.3%	1,027.2	43.6%	404.7	17.2%	2,358.7
Network 18 (AZ, NM & W TX)	904.8	58.4%	175.7	11.3%	467.6	30.2%	1,548.1
Network 19 (Rocky Mountain)	947.6	62.1%	369.5	24.2%	209.1	13.7%	1,526.2
Network 20 (Pacific NW)	1,261.9	40.2%	1,416.6	45.2%	457.3	14.6%	3,135.8
Network 21 (Northern CA)	1,321.6	44.2%	1,112.3	37.2%	556.8	18.6%	2,990.7
Network 22 (Southern CA)	957.3	35.3%	1,076.1	39.7%	675.9	24.9%	2,709.3
National	33,577.2	53.2%	18,080.2	28.7%	11,423.8	18.1%	63,081.2

This table displays long-term care workload by network, shown in average daily census (ADC), for FY 1997. The nursing home census is shown in Column 2, enriched housing in Column 4, home- and community-based care in Column 6, and total ADC in Column 8. Each workload column is followed by the percent of the total it represents. For example, nationwide, the nursing home ADC was 33,577.2, which was 53.2 percent of all long-term care workload in FY 1997.

Sources: AMIS, CDR, and State Veterans Homes Reports

Table 4: VA Long-Term Care Costs, 1997

FACILITY NETWORK WORKLOAD	TOTAL NH OBLIGATIONS	NH PERCENT OF TOTAL	ENRICH HOUSING OBLIGATIONS	EH PERCENT OF TOTAL	CBLTC OBLIGATIONS	CBLTC PERCENT OF TOTAL	TOTAL LTC OBLIGATIONS
Network 1 (New England)	$ 102,464,980	85.8%	$ 8,810,381	7.4%	$ 8,122,696	6.8%	$ 119,398,057
Network 2 (Upstate NY)	$ 54,868,999	72.8%	$ 11,643,024	15.4%	$ 8,868,253	11.8%	$ 75,380,276
Network 3 (Downstate NY)	$ 124,176,797	85.8%	$ 11,330,321	7.8%	$ 9,294,334	6.4%	$ 144,801,452
Network 4 (PA & DE)	$ 130,221,391	88.2%	$ 10,550,735	7.1%	$ 6,825,138	4.6%	$ 147,597,264
Network 5 (MD & DC)	$ 48,201,551	74.9%	$ 11,672,099	18.1%	$ 4,502,205	7.0%	$ 64,375,855
Network 6 (VA & NC)	$ 83,602,580	86.5%	$ 8,755,418	9.1%	$ 4,338,437	4.5%	$ 96,696,435
Network 7 (AL,GA & SC)	$ 78,572,596	86.2%	$ 7,675,363	8.4%	$ 4,902,456	5.4%	$ 91,150,415
Network 8 (Florida)	$ 92,479,848	85.3%	$ 5,872,712	5.4%	$ 10,018,290	9.2%	$ 108,370,850
Network 9 (KY & TN)	$ 47,570,802	78.8%	$ 9,150,923	15.2%	$ 3,647,572	6.0%	$ 60,369,297
Network 10 (Ohio)	$ 70,587,878	76.1%	$ 14,628,704	15.8%	$ 7,485,200	8.1%	$ 92,701,782
Network 11 (IN & MI)	$ 84,095,693	92.4%	$ 1,207,633	1.3%	$ 5,725,604	6.3%	$ 91,028,930
Network 12 (Chicago & WI)	$ 108,894,766	82.1%	$ 13,103,238	9.9%	$ 10,645,832	8.0%	$ 132,643,836
Network 13 (MN, ND & SD)	$ 66,293,429	86.2%	$ 6,064,859	7.9%	$ 4,561,000	5.9%	$ 76,919,288
Network 14 (IA & NE)	$ 38,025,221	83.8%	$ 5,502,741	12.1%	$ 1,826,255	4.0%	$ 45,354,217
Network 15 (KS & MO)	$ 64,858,900	81.7%	$ 10,397,368	13.1%	$ 4,136,614	5.2%	$ 79,392,882
Network 16 (AR, LA, MS, OK)	$ 94,690,777	85.3%	$ 8,040,444	7.2%	$ 8,258,744	7.4%	$ 110,989,965
Network 17 (Most of TX)	$ 57,358,876	71.5%	$ 17,367,931	21.7%	$ 5,445,652	6.8%	$ 80,172,459
Network 18 (AZ, NM & W TX)	$ 53,273,205	82.1%	$ 5,849,345	9.0%	$ 5,802,013	8.9%	$ 64,924,563
Network 19 (Rocky Mountain)	$ 49,149,414	93.1%	$ 918,580	1.7%	$ 2,708,828	5.1%	$ 52,776,822
Network 20 (Pacific NW)	$ 55,790,762	62.5%	$ 26,575,054	29.8%	$ 6,921,220	7.8%	$ 89,287,036
Network 21 (Northern CA)	$ 81,065,211	82.2%	$ 9,699,104	9.8%	$ 7,882,400	8.0%	$ 98,646,715
Network 22 (Southern CA)	$ 75,058,305	82.5%	$ 8,255,544	9.1%	$ 7,702,531	8.5%	$ 91,016,380
National	$ 1,661,301,981	82.5%	$ 213,071,521	10.6%	$ 139,621,274	6.9%	$ 2,013,994,776

This table displays long-term care costs by network for FY 1997. The nursing home cost is shown in Column 2, enriched housing in Column 4, home- and community-based care in Column 6, and total cost in Column 8. Each cost column is followed by the percent of the total it represents. For example, nationwide, the nursing home cost was $1.7 billion, which was 82.5 percent of all long-term care costs in FY 1997.

Sources: CDR and State Veterans Homes Reports

Appendix E:

Long-Term Care Quality Index

In the course of its work, the Committee developed ideas for a long-term care quality index, which would standardize and measure the quality of care delivered to VA health care beneficiaries. Following is an outline focusing on the structure of such a system.

Structure

A. Continuum of Care

A full continuum of geriatrics/extended care services would exist, either within the facility or easily accessible within the network, or by contract. The continuum would include, at a minimum, acute, intermediate, nursing home, domiciliary, and home care; outpatient services; and hospice and respite care. It would employ a full range of geriatric services, including comprehensive geriatric assessment, primary care provider, care management, and rehabilitation.

B. Clinical Pathways

Clinical pathways, or standardized clinical treatment protocols, have been defined for the management of common clinical conditions. Under the proposed quality index, each network would be required to adopt three guidelines that are most relevant to its long-term care patient population.

Pathways have been developed for the following:

•Urinary Incontinence	(Agency for Health Care Policy and Research, American Medical Directors Association)
•Benign Prostatic Hyperplasia	(Agency for Health Care Policy and Research)
•Pressure Ulcer Prevention	(Agency for Health Care Policy and Research, American Medical Directors Association)
•Fall Prevention	(Health Care Financing Administration/Resident Assessment Protocols)
•Post-Stroke Rehabilitation	(Agency for Health Care Policy and Research)
•Alzheimer's Disease	(Agency for Health Care Policy and Research, VA)
•Depression	(Agency for Health Care Policy and Research, American Medical Directors Association, VA)
•Palliative Care	
•Nutrition	
•Acute Confusional State	

Process

A. Systematic Screening

Every patient over age 70 deemed at risk for needing long-term care services by standardized criteria would be screened every one to two years for frailty and geriatric care needs. A younger threshold age could be selected if screening resources permit. Screening could be performed by a trained interviewer or by a self-administered

questionnaire, and should include questions on functional status, mood, memory, social isolation, nutrition, ambulation, and specific disabilities.

B. Targeted Assessment and Care

For veterans identified through screening as frail, or having problems that interfere with health and function, the following steps should be taken:

- A comprehensive assessment is performed, including assessment of medications, functional status, cognition, affect, gait/balance, nutrition, social support system, and special senses.
- Referral for appropriate services.
- Verification of treatment, and follow-up services as needed.

C. Care Coordination

The care coordination process must include an interdisciplinary treatment plan with regular updates. Admissions to nursing homes or other long-term care programs or services would occur following an assessment by a care coordinator or interdisciplinary team.

D. Advance Directives

Advance directives should be discussed with the patient or appropriate surrogate and documented.

Outcomes

A. Medical Complications and Adverse Events

As with all health care services, specific adverse events and complications would be expected to occur at acceptable rates. Networks should have the opportunity to choose two or more specific outcomes to monitor. All quality indicators will use established Health Care Financing Administration definitions to provide comparisons with the long-term care industry. These include:

- Nosocomial Infections
- Falls
- Adverse Drug Effects
- Pressure Sores
- Restraint Use
- Malnutrition
- Chronic Indwelling Bladder Catheter Use Without Appropriate Indications.

B. Acute Care Services

Admissions and readmissions to hospitals and emergency room visits would be monitored.

Appendix F:

Sources

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Geriatrics and Extended Care

The mission of the Geriatrics and Extended Care (G/EC) Strategic Healthcare Group (SHG) is to advance quality care for aging and chronically ill veterans in the most efficient manner. The G/EC SHG provides policy direction for the development, coordination, and integration of geriatrics and long-term care through research, education, and evaluation of new clinical models.

All G/EC programs seek to prevent or lessen the burden of disability on older, frail, chronically ill patients and their families/caregivers, and to maximize each patient's functional independence. Because the source of chronic illness often is inconstant, the healthcare needs of the chronically ill patient change, requiring the services of one, some, or all G/EC service lines over time. The cross-cutting functions of the SHG underscore a common purpose, and link the G/EC services lines to each other and to the shared missions of other SHGs, including rehabilitation, primary care, and mental health.

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